IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

MINNIE TAYLOR, Individually and
as Personal Representative of
the ESTATE OF LOUIE TAYLOR,
and HAROLD CUTHAIR,

Plaintiffs,

vs. Case No.
21-cv-00613-GJF-JFR
THE UNITED STATES OF AMERICA,

Defendant.

DEPOSITION OF VIRGINIA E. HARVEY, M.D.

March 25, 2022
8:30 a.m.
via videoteleconference

PURSUANT TO THE FEDERAL RULES OF CIVIL PROCEDURE, this deposition was:

TAKEN BY: MS. CHRISTINE H. LYMAN
Attorney for the Defendant

REPORTED BY: MABEL JIN CHIN, NM CCR #81
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enclosed a summary of facts." It says "The summary of facts provides a timeline of when Mr. Taylor was taken into custody to when he died in his jail cell." How did the summary of facts play into your opinions in this case?

A. The summary of facts allowed for me to better understand the circumstances surrounding the death of Mr. Taylor, so it did play into my opinions insofar as it elucidated how he presented to the jail and how he acted in the jail prior to his death.

Q. Am I correct to say, though, that your opinion doesn't really go into timing in terms of -- well, I guess I don't remember seeing anything about if X happened at Y time the result would have been different; is that correct? Is that fair?

A. I don't -- I don't quite understand the question.

Q. Although I recall seeing in your report -- and we'll go into this later -- that you go through a timeline, a summary of facts, your opinion doesn't really have a timeline; is that correct?

A. Um -- my opinion, as far as I recall, does not have a -- just give me one second to pull up my opinion.

Q. Sure. Take your time.

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A. So my opinion in the summary of events certainly does have a timeline within the summary of of events, including when the police were dispatched, when Mr. Taylor was detained, when he was booked and when he was found unresponsive. So that timeline is reflected in my summary.

Q. And I apologize, I feel like I'm not making myself clear enough, and I apologize for that. But I guess I was referring to your medical opinions in this case. So if you scroll further down or look, you know, to after the factual summary --

A. Okay.

Q. -- when you talk about the clinical findings and your opinions about what could have happened in this case, are you -- did that timeline factor into those opinions?

A. My opinion in this situation is essentially that there was a patient who was displaying evidence of a medical emergency, including hallucinations and agitations, and had he been afforded timely medical care he likely could have been saved prior to succumbing to his cardiac arrest.

Q. And given that you were given this timeline by Mr. Buffington's firm, that timeline, when did it start? And feel free to look at it, because I think

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it's part of the file.

A. Yes. So I have February 29th, 2020 at 7:48 p.m. a sergeant from the Navajo Nation Division of Public Safety was dispatched to a residence regarding a male.

Q. Okay. So is it fair to say that when considering this case, that in your analysis you are just starting at 7:48 p.m.?

A. Correct.

Q. So you don't know anything that happened before 7:48 p.m. on February 29th, 2020?

A. That is correct.

Q. And you were not asked at all to consider or think about that time period; is that correct?

A. Prior to the -- no, that is correct.

Q. Okay. And so I will scroll back up to where we just were. So, I think you alluded to this, but in this paragraph -- I think it's the third paragraph of the letter, and I'm going to highlight it here -- it says "We would appreciate receiving your written opinion regarding a narrow question. Given the amount of amphetamine and methamphetamine found in Mr. Taylor's system noted on the toxicology report, could Mr. Taylor have been saved if he received timely medical intervention?" Does that accurately summarize

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what you were asked to do in this case?

A. Yes.

Q. Is it fair to say that they are not asking you about what caused Mr. Taylor's death?

A. That is fair to say.

Q. Is it fair to say that you are -- you are relying on the autopsy results to provide you with the cause of death?

A. I'm relying on the autopsy results and the clinical picture that was painted by the documents provided, and then subsequently by the video evidence that I reviewed.

Q. Did you independently determine a cause of death, in your opinion?

A. No. I do not think it's possible for me to do that based on the documentation that I received.

Q. And why is that?

A. Well, Mr. Taylor didn't have a medical exam, so certainly we are relying on the autopsy report. And I do not argue with the autopsy report, but when a patient presents with hallucinations and agitation, the differential diagnosis is very wide. And so, the patient did not receive a medical screening exam so there are things that could have caused his death that we were not able to ascertain because he was not

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evaluated.
Q. So you are saying that because an evaluation didn't happen while he was still alive, you find it -- I don't want to put words in your mouth -- but do you find it impossible to determine his cause of death independently, or how would you characterize whether you can do that or not?
A. I mean, I would rely on the medical examiner to determine his cause of death.
Q. Okay. So you are relying, then, on that autopsy and the finding?
A. Yes.
Q. Thank you. And is it also fair to say that you were not asked to provide an opinion about whether any particular person's conduct caused or contributed to Mr. Taylor's death; is that correct?
A. Correct.
Q. Okay. I'm going to now scroll down again, and I apologize, page 19. Okay.
So here are some E-mails between you and Ms. Fosbinder. This one is dated January 19th, 2 o'clock, and you say, "Ms. Fosbinder, Upon review of documents provided for Mr. Louie Taylor, I do have one additional question. Please let me know if you are available today or tomorrow for a very brief one- to

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two-minute phone call." So, do you recall what this question was?
A. As I recall, it was wondering if there was -- let me just -- if there was an intake form provided at the jail that included a set of vital signs and any further medical information.
Q. And what did Ms. Fosbinder tell you about that?
A. She did provide me with the intake form.
Q. And that was -- that responded to your question, then?
A. Yes.
Q. So I see it says, and I'm scrolling further down the page, it looks like there was an attachment, "Louie Taylor Medical Screen and NNMC records.PDF." Can you tell me what documents were included in this PDF?
A. That was just, like I said, the documentation regarding the screening form that is performed by the jail. And then I believe during that -- it also included the medical records from his presentation in cardiac arrest to the hospital.
Q. So those would have been medical records from Navajo -- sorry -- Northern Navajo Medical Center on March 1st, 2020; is that correct?

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A. Yes.
Q. Do you recall ever receiving any other medical records regarding Mr. Taylor from prior to his death?
A. I do not recall receiving anything.
Q. And then I see, then, in this response from Ms. Fosbinder, that she says, "Unfortunately -- we, unfortunately, do not have a copy of the EMS report when Louie was transported from jail after he was found unresponsive." Is that something that you asked her about?
A. I do not think that I asked her about that specifically.
Q. Okay. So I'm going to now scroll down to the next page, page 20 of this PDF. Sorry. This is taking me a little bit longer than -- there we go.
So I see an E-mail dated January 24th, 2022 from you. You say "Tracy, I have completed the requested draft report for Mr. Taylor. How would you like to receive it?"
In doing your work in this case, Dr. Harvey, did you create one or more drafts of this report?
A. I did not. I have my report and I have the addendum.
Q. Okay. So you didn't have, you know, working

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drafts that you edited and then finalized?
A. No.
Q. Okay. And so I noticed that you are asking about sending an E-mail -- or sorry, sending your draft via E-mail to Tracy. That would be your final draft, then; correct?
A. Correct.
Q. And I noticed, though, that your report is dated January 18th, 2022. Is it fair to say that that date is inaccurate?
A. No. It's likely that I finished it on that day and sent it on the 24th.
Q. Okay. So -- all right. Well, let's look at -- well, let's turn to the first page of this PDF.
Sorry, I didn't want that page. I wanted your invoice, which I think is below here.
So I'm looking here at the second page of the PDF. It's an invoice and your name is at the top.
A. Okay.
Q. It says "Re: Louie Taylor."
A. Yes.
Q. So the first entry it says, document review and report writing, 1/18/2022, 47 minutes.
A. Okay.
Q. Does this refresh your recollection as to

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patient will likely require during their emergency stay.

So a level 1 patient is very, very sick and near death. They are essentially a patient that requires resuscitation and will require a lot of resources. And then a level 5 patient is somebody who needs to have, for example, a suture removed and requires very few resources. And then, 2s, 3s and 4s lie in between those. When a patient is assigned an ESI, they are typically brought back from the waiting room based on their ESI level.

Q. So, when you say brought back from the waiting room, are you saying that after they have been assigned an ESI level, then people are, I guess, seen kind of in the order of severity?

A. Correct.

Q. Okay. So, if you are, let's say, a lower level of severity, like a 3 or 4, you would be expected to wait in the waiting room until people with higher scores -- or sorry, lower scores of severity have been assessed; is that right?

A. It's -- that is generally true, although many emergency departments have a dedicated area called -- sometimes it's called a fast track, where there is one provider that can see those patients in

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an area that is designated to be lower acuity without taking up the resources that the higher acuity patients would require. So it isn't necessarily like you would wait in the ER all day until all of the 2s and 3s would go, but there are sometimes two tracks.

Q. Okay. But you don't know what the system was at Northern Navajo; correct?

A. I don't, but the hospitals that I have worked at have all used the ESI criteria to determine patient acuity, resource utilization, anticipation.

Q. But you don't know whether Northern Navajo had this extra person, fast track type of situation?

A. I have no -- no, I do not know what their staffing model is up there.

Q. Okay. Well, so, is it fair to say that people often wait in the emergency department to be seen after they have been triaged?

A. It is.

Q. Do you happen to know what the wait times are at your hospital?

A. I don't know, and it really varies based on how sick somebody is. So, the wait times have been very short when there is nobody waiting, we can bring them right back into the triage in the room. But when the ER is busy, the wait times can be upwards of, you

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know, three hours.

Q. Is it uncommon to have wait times of over three hours in an emergency room, in your experience?

A. It really depends on the emergency room.

Q. Okay. So, you said that people who are brought in by the police sometimes go through the ambulance bay. Is there a different triage process, or how does that work for people who come in through the ambulance bay?

A. So, at my hospital patients come in through the ambulance bay. They are seen by the charge nurse, who is the nurse that oversees the department and manages the flow of the department. And the charge nurse asks the police or the paramedics, because they both kind of present through the same pathway, what the chief complaint is, what recent sets of vital signs have been obtained, and kind of makes a very quick assessment of the severity of the patient's condition. And then the triage nurse typically then assigns the patient and the police officer a room at that time.

Q. Okay. And then after they are assigned a room in your -- just -- this is at your hospital or the hospitals you worked at, how long is it until they see a doctor?

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A. It's usually pretty quick.

Q. And is it usual that a doctor has to see them, or is it enough that the nurse, the charge nurse or the triage nurse has taken a look?

A. No. The doctor has to see them and provide a medical screening exam.

Q. And what is involved in a medical screening exam, in your experience?

A. So the first part is to obtain a history of the patient to figure out what they are presenting with. Everybody gets a set of vital signs to see if there are any major vital sign abnormalities, and then everything kind of flows from there. So, the patients that come to the emergency department in a medical screening exam are vast. Some patients come in because they hit their head three days ago and they just need someone to say that they are okay. Some patients come in with severe medical emergencies that require admission to the hospital or transfer to an intensive care unit. The severity of patients presenting using medical -- for a medical screening exam is wide.

Q. And so, are there specific criteria that are used to determine whether somebody, I guess, is clear to go?

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A. There are not specific criteria. It is based on the medical experience and the decision of the provider or the physician taking care of them. So as an emergency medicine physician, we are trained to recognize and respond to acute medical conditions. And if we find that there is none, then, we think that the patient is safe to go home.

Q. Or to go to jail if they are being booked into jail?

A. Correct.

Q. Let's see. So, in your experience in the emergency department of various hospitals, you talk about sometimes having people do drug screens for meth and I think you mentioned it was a urine test; is that right?

A. Correct.

Q. Can you explain to me how these urine tests work?

A. Um -- I don't know the laboratory processes for determining the different metabolites found in the urine samples.

Q. Are you saying that it is only testing for meth metabolites, or is it testing for meth itself?

A. No, it's testing for meth, but it's a rapid urine drug screen, so it's a set of drugs that are

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screened on one sample. It's actually not even meth, it's just amphetamines. They are often screened for cocaine, THC, and various other illicit substances.

Q. In the urine test, you said it's a qualitative test; correct?

A. It's qualitative.

Q. So, that means you don't know the actual concentrations that are presenting; correct?

A. Yes.

Q. Do you happen to know any information about false positives or negatives coming from urine tests?

A. I am sure that there are false positives and false negatives if patients are on -- you know, if a patient takes medication for ADHD they can certainly screen positive for amphetamines and them not taking methamphetamine.

Q. What medications for ADHD are you referring to?

A. Like Adderall, methylphenidate.

Q. What is -- I'm sorry, what is Adderall?

A. It is a medication used to treat ADHD.

Q. But what is the chemical?

A. Amphetamine derivative.

Q. So it's an amphetamine derivative that could cause false positives in a urine drug screen at a

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hospital?

A. Yes.

Q. How long does it generally take to get the results back from a urinalysis for testing for drugs?

A. Um -- an hour, I would say, roughly.

Q. Is it fair to say, Dr. Harvey, that in the clinical setting that you do not generally get quantitative drug screen results for drugs?

A. Not for that drug.

Q. Okay. And why is that?

A. Because it doesn't change the outcome. There are certain drugs that you do need to get a quantitative screen. So, if somebody comes in with a Tylenol overdose, it matters a lot what their serum level of Tylenol is and the time since ingestion and that determines how you treat the patient. But in this circumstance, it does not matter.

Q. Do you happen to know if your hospital has laboratory capabilities for doing quantitative testing for methamphetamine?

A. I don't think that we do, but I'm not sure that we don't.

Q. Okay. And you don't know whether any labs -- or sorry -- any hospital such as Northern Navajo has that capability?

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A. I don't know.

Q. Okay. And do you generally know how long it takes to do a quantitative test for methamphetamine?

A. I don't know how long it takes.

Q. Okay. Now, I want to turn back to your report here. And so, I wanted to ask you about when you say moderate to severe methamphetamine toxicity, is this a qualitative determination?

A. No.

Q. So, tell me what you mean by moderate to severe. What does that mean to you?

A. Sure. So, I have had patients come to the emergency department telling me that they have taken methamphetamine and they don't feel well, and I would consider those patients mild toxicity. Somebody who is experiencing active hallucinations, I would say they are experiencing at least moderate to severe toxicity based on their clinical presentation.

Q. What about somebody who is, you know, having some of these what you refer to as potentially life-threatening complications? Are these moderate? Severe? How would you classify these life-threatening complications?

A. I think if somebody is having a life-threatening complication to methamphetamine

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are one of the peer reviewers?
A. Yes.
Q. And you did rely on this Critical Care article to support your opinions in this case; is that right?
A. Yes.
Q. So, would you agree that this particular article is a reliable and authoritative source of information about meth toxicity levels?
A. I would.
Q. Okay. And so, the therapeutic and the toxic columns in that article, to your knowledge, are these antemortem or postmortem values?
A. I would have to review the article again.
Q. Okay. But can we assume, though, that if the values are taken from people who didn't die of meth toxicity, that these would be antemortem values?
A. I would have to look at the article again.
Q. Okay. And so, are you assuming for purposes of this opinion that antemortem blood concentrations of methamphetamine are going to be similar to postmortem blood concentrations of methamphetamine?
MR. BUFFINGTON: Objection, form and foundation. Answer if you can, Doctor.
A. I think that a lot of things -- the time

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since death matters. I don't think that you can correlate them. I think there are a lot of variables.
Q. Okay. So you can't tell me, sitting here today, whether an antemortem meth concentration is going to be comparable to a postmortem meth concentration level without having further information?
A. Correct.
Q. Okay. Now, what you say here is that -- um -- "Therefore, while Mr. Taylor was clearly suffering the toxic effects of methamphetamine, made most obvious at the time by his clinical presentation, his postmortem femoral blood concentrations were not exceptionally high as to suggest an unsurvivable overdose, and he likely could have been saved by timely medical intervention."
So, this is a lot to unpack but I would like to ask you, are there any specific medical interventions you have in mind here?
A. So, I certainly think that he should have been evaluated. He didn't receive any medical intervention. And I think this sentence really is the crux of what I believe, is that his clinical presentation at the time is the most telling sign that he is having a medical emergency, specifically

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agitation and hallucination.
So, if this person was brought to me for a medical clearance in this state, I would have done things that we discussed previously. I would have gotten a history from him if I could, from the police. I would have obtained a set of vital signs. I would have given him some fluids and checked some labs. I would have seen if there were any obvious reversible medical problems that were contributing to his condition.
I think his clinical presentation is really the finding that is most concerning to me.
Q. But sitting here today, you cannot identify a specific medical intervention that you believe would have saved his life?
A. A medical screening exam would have been the intervention. It would have been the opportunity to provide him with medical care is the intervention. We don't know what he -- what was going on because he was not provided the care.
Q. Okay. So, you are saying that he should have been given some kind of medical screening?
A. Yes.
Q. Okay. Now, I'm going to go down to your opinions. I think some of this is repetitive of what

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we talked about before so we don't need to go into it.
Here you say "Patients who suffer acute methamphetamine toxicity are at risk for several life-threatening, yet largely treatable complications." I would like to know what you mean by largely treatable, because seems to imply to me, at least, that sometimes it might not be treatable?
A. I mean, certainly, so -- I mean, that's how emergency medicine is. People show up in all sorts of conditions and you do your best, and sometimes you can't save them no matter what you do, and that is just the case of it. But usually not. Usually when patients present to the emergency department with a medical emergency, there are people there who are trained to respond to their medical emergencies. And these medical emergencies, these life-threatening complications, including hyperkalemia, including acidemia, seizures, they are largely treatable, sometimes not, but that's just how it goes.
Q. Okay. So you can't say 100 percent sure that it would have been treatable if he had gotten the screening?
A. I can't say for 100 percent sure that anybody -- I mean, 100 percent is 100 percent that -- you can't say that.

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Q. Okay. So, now, we touched upon this a little bit earlier, but you said that from documentation provided, Mr. Taylor had no significant medical comorbidities and there were no findings on his autopsy that would suggest an unsurvivable co-condition. So tell me what medical documentation you reviewed pertaining to Mr. Taylor to reach this opinion?

A. So, I reviewed the documentation that was provided regarding his visit to Northern -- the hospital that he presented at in cardiac arrest, and I reviewed the subsections for previous surgeries, medical history, and there were no significant findings in that documentation, for medical history in that documentation.

Q. Do you recall when his last physical exam was?

A. I don't.

Q. Okay. Do you recall whether it was in the last ten years?

A. I don't.

Q. Do you recall if was in the last 15 years?

A. I don't, but I can certainly re-review the medical records that I was provided.

Q. Okay. So, other than the history that might

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have been captured in the hospital records from that one visit, you were not provided any other medical records pertaining to Mr. Taylor when you wrote this report?

A. Correct.

Q. Okay. So, then you say, in the sentence that there were no findings that would suggest an unsurvivable co-condition, what do you mean by that?

A. There were no other findings on autopsy like an aortic dissection, like, there was nothing on autopsy that suggested that he had a catastrophic condition that he was unsavable from.

Q. Now, I think, if I recall correctly, when we talked about some of those conditions you said you either didn't know about how they would present on autopsy or you wouldn't expect to see something on autopsy. Are there conditions that could kill you that you might not be able to detect from an autopsy?

A. Well, it really depends on what the autopsy looks for. I don't know if this autopsy looked for slides, if there was any histopathology. I don't think you would be able to see any electrical abnormalities because those are kind of real-time, and also electrolyte abnormalities, unless you took a sample of the blood or you had a sample from the

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emergency department to detect those abnormalities.

Q. Okay. Then you say in the next sentence, "Additionally, and notwithstanding limitations in the interpretation of postmortem blood concentrations for toxic substances." Can you explain to me what these limitations in the interpretation of postmortem blood concentrations are?

A. I mean, I think we talked about those already. There's you can be habituated and have the ability to withstand certain -- the toxic effects of certain substances if you take them routinely, and then also, your underlying medical comorbidities. Those all determine how you will react or respond to any of these substances.

Q. And then also redistribution could also be a factor?

A. Yes.

Q. Okay. And then at the very bottom here you state that "It is there for my medical opinion to a reasonable degree of medical" -- I think this should be "certainty"?

A. It is. I'm sorry.

Q. -- "that had Mr. Taylor been afforded timely and appropriate medical care it is likely that the toxic effects of methamphetamine could have been

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discovered and treated, thereby preventing his death." So, first of all, when you say timely, is there a particular point in time that you think he should have been seen in the hospital?

A. I think any time prior to his cardiac arrest would have been good.

Q. But you didn't specifically consider any time prior to -- I think you said 7:48 p.m. on February 29th, 2020; correct?

A. Well, I don't know what was happening prior to that time. There was no documentation provided to me of what he was doing the rest of that day.

Q. Okay. If you -- hypothetically speaking, if you knew that Mr. Taylor had been displaying similar symptoms the day before, would your opinion also be that he also should have been treated the day before or screened the day before?

A. Yeah. If he was having hallucinations and was agitated, I certainly think, especially if he was taken into custody and was under the care of somebody else, he should have been brought to the -- he should have presented for treatment.

Q. Is your opinion limited to if he had been in custody, or should he have been taken for treatment even if he hadn't been in custody?

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A. I think if he was hallucinating and agitated he would have benefited from a medical evaluation.

Q. Okay. And then when you say appropriate medical care, are you assuming that is a type of medical care that you said that you would provide if you had seen Mr. Taylor that day?

A. Yes.

Q. Okay. Now, I would like to now move to your addendum report, and I am going to put it up in just a second here.

A. Sure.

Q. Let me make it a little bit bigger.

So, this addendum report, does this look like the addendum report you drafted on or about February 7, 2022?

A. Yes.

Q. Okay. And is that your signature at the bottom here?

A. It is.

MS. LYMAN: Okay. Mabel, I would like to mark this as Exhibit 7.

(Exhibit 7 marked.)

Q. (By Ms. Lyman) So, I notice up here that you cite additional -- you say since submission of your original report, you have been provided and have

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reviewed the following document, and it is the EMS report; is that right?

A. Yes.

Q. And is that the only information that you received that you considered in formulating this opinion in your addendum?

A. Yes.

Q. Okay. Now, what you say here, you provided Summary, and this is taken from the EMS report; is that correct?

A. Correct.

Q. And so I'd just like to turn to the Discussion. You say "Prior to his death, Mr. Taylor was displaying symptoms of moderate to severe methamphetamine toxicity as manifested by his significant psychomotor agitation, hallucinations, and paranoia." And just -- I think we touched on it earlier, but this is just based on what you have seen in the record; correct?

A. Yes.

Q. And there was no effort to do any kind of differential diagnosis because -- well, could you even do a differential diagnosis of him at this point?

A. Based on what I saw in the record?

Q. Yes.

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A. I mean, certainly I have a differential diagnosis that -- but it's difficult to kind of rule things out or rule things in based on not seeing Mr. Taylor.

Q. Okay. And not having things like labs, for example?

A. Right.

Q. Okay. So, you talk about hyperthermia, which we discussed. You say it's a "well-known and treatable complication of methamphetamine toxicity which can itself lead to respiratory failure, cardiac failure seizures, kidney injury, and sever electrolyte imbalance, which can ultimately result in PEA and death." What is PEA?

A. PEA is an acronym for pulseless electrical activity.

Q. And how does hyperthermia cause PEA?

A. So, hyperthermia can lead to these complications. You can become acidemic, you -- which can lead to PEA. You can have rhabdo, become hyperkalemic, kidney failure, and they can all lead to a pulseless electrical activity.

Q. And so, that was the condition Mr. Taylor was in when the EMTs came?

A. Yes, as far as I know.

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Q. And does PEA indicate any kind of cardiac event happening, in your experience?

A. So, PEA is a lot of different etiologies. It can be cardiac. Cardiac can also cause ventricular fibrillation and ventricular tachycardia.

Q. So, just knowing that somebody is found in a state of PEA, there's no way to tell necessarily what is causing the PEA?

A. No. So, if somebody is in the hospital you go through something called your Hs and Ts. You think of -- for H -- and this is not exhaustive -- there is hypoxemia, there's, you know, hyperthermia. For Ts there's thrombosis, there's tension pneumothorax. So there are multiple things can cause PEA, and it's difficult to determine exactly which one caused it without doing a more thorough evaluation.

Q. So, down here you say "It is my opinion to a reasonable degree of medical certainty that Mr. Taylor's hours-long period of psychomotor agitation, described as kicking, punching, yelling and pacing, while being contained in a cell described by a medical professional as," quote, "like a sauna," end quote, "placed Mr. Taylor at a very high risk for severe methamphetamine-associated hyperthermia, which is life threatening but treatable with timely and

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quality medical care." So I would like to unpack this a little bit.

A. Sure.

Q. What is your basis for stating that Mr. Taylor was having an hours-long period of psychomotor agitation?

A. I'm going to look at the summary of facts that I have. Is that okay?

Q. Sure.

A. So, let me pull it up.

So I'm looking at the in-custody death investigation, Bates Number 001858.

Q. Sorry. Let me see if I can pull it up here.

A. Sure. That's it.

Q. So, tell me, point to me where it says that he was undergoing hours-long psychomotor agitation?

A. So, I'm looking at number 3. From the timetable it looks like in the cell he was displaying abnormal behavior by kicking, punching, and pacing in a circle in his cell.

Q. Okay. So his behavior captured on facility video.

A. And then -- so, throughout his time in the isolation cell he was yelling and pacing.

Q. Well, isn't it true that it was noted that

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six cell checks were conducted, and those cell checks noted that he was yelling and pacing? Do you have any way to know from this whether he was pacing the entire time, or was it just during those checks?

A. There is no way for me to know based on this.

Q. Okay. So, you are just assuming, then, that the entire time he was in the cell he was in psychomotor agitation; correct?

A. Well, the six times that they checked on him, it seems from this that during all six of them he was yelling and pacing in his cell.

Q. But you are extrapolating from that the fact that he must have been pacing at every other time, even when he wasn't checked; is that correct?

A. Yes.

Q. So, turning back to your report, now, you talk about the cell being described by a medical professional as like a sauna. You are referring to the EMT; correct?

A. Yes.

Q. Do you know at what time the EMT arrived in the cell?

A. I have it here. It looks like it was 12:12 a.m.

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Q. Okay.

A. According to the report filed.

Q. 12:12 a.m. Okay. Do you have -- well, is there any way to know if the cell felt like a sauna before 12:12 a.m.?

A. No.

Q. Okay. So you are assuming, then, that both the entire time that he was in his isolation cell he was in a constant state of psychomotor agitation and that his cell was like a sauna the entire time. Are those two assumptions that you are basing your opinion on?

A. Yes. But they are assumptions that were made based on the experiences from the people who were there, based on what they have written.

Q. Okay. But you cannot say for sure what the condition of the cell was in the time, the three-and-a-half hours before the EMTs arrived; is that correct?

A. That is correct.

Q. Okay. Now, what you say here, though, is that he was at very high risk for severe methamphetamine-associated hyperthermia. Are you saying he did have severe methamphetamine-associated hyperthermia, or he could have had it?

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A. He could have had it.

Q. Is there any way to confirm this?

A. No.

Q. And are you basing this on any clinical observations, or just what is listed here?

A. I don't think that there are any clinical observations to be made because the patient did not receive a medical evaluation. I am basing this on my experience wherein if a patient came to the emergency department experiencing hallucinations and severe psychomotor agitation, I would do my best to keep them calm and cool and in an environment where they could be monitored and cared for.

Q. Do you -- if somebody was experiencing severe methamphetamine-associated hyperthermia, would you expect them to be diaphoretic?

A. Typically, yes.

Q. Okay. So, just so that I am clear, in this addendum you are not pointing to any clinical findings of hyperthermia; correct?

A. Correct.

Q. And you are also not pointing to any autopsy findings indicating hyperthermia; correct?

A. I did not see any.

MS. LYMAN: Okay. And I am almost done,

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actually. I was wondering if you guys would be okay if we just powered through the last two pages of my outline, and we can be done, or would you like to take a break and break for lunch?

MR. BUFFINGTON: Could we take about a five-minute break? I hear my dog doing something strange.

MS. LYMAN: Okay.

(A discussion was held off the record.)

(A recess was taken from 12:19 p.m. through 12:24 p.m.)

Q. (By Ms. Lyman) Okay. So, Dr. Harvey, I would like to now turn to what I will be showing you on my screen here, so let me start sharing.

Do you recognize this article here?

A. I do.

Q. And what is this article?

A. This is an article about acute -- methamphetamine acute intoxication.

Q. And is this the article that we discussed from UpToDate that is cited in your original report dated January 18th, 2022?

A. Yes, it looks like it.

MS. LYMAN: Okay. Mabel, I would like to mark this as Exhibit 8. And I know I sent you a

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different one as Exhibit 8, but I would like this exhibit to be Exhibit 8, and the original Exhibit 8 to be Exhibit 9.

(Exhibit 8 marked.)

Q. (By Ms. Lyman) So this is an article that you relied on in formulating your opinions in this case; correct?

A. Mostly as a refresher.

Q. Okay. So I wanted to turn to page 10, and I am sorry, but my mouse is acting up a little bit so -- okay. Got it back. And something that I was curious about because I noticed it in this article is, "Sudden cardiac arrest." Can you tell me what sudden cardiac arrest is?

A. It is -- it is sudden. It's when your heart stops suddenly.

Q. Is sudden cardiac arrest a known complication for meth intoxication?

A. Yes.

Q. And so, how does it differ from the ones we talked about, such as heart attack and arrhythmia?

A. So when a patient presents with agitation and hallucination, you -- I don't understand quite the question. So there are -- how is it different? It's a different entity.

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Q. Okay. So it's different from arrhythmia, it's different from heart attack; correct?

A. Yes.

Q. Okay. And so, I guess, tell me what -- how does a person in sudden cardiac arrest present?

A. A person in sudden cardiac arrest usually presents nonresponsive with no pulses.

Q. Now, tell me what -- how would you treat somebody who presents that way?

A. So you would have to figure out why they arrested, and it's some of the same pathways that we talked about earlier. Did they arrest because they were having a heart attack? Did they arrest because they had a fatal pulmonary embolism? Do they have severe renal dysfunction? Most pathways eventually lead to cardiac arrest.

Q. But in terms of, you know, if a person is presenting in the hospital pulseless and unresponsive, how would you treat that person?

A. Well, it depends what the arrest is. So, if someone is suffering from a V-fib arrest, so a ventricular fibrillation, you would shock them. If somebody is presenting in PEA you would try to determine how they entered PEA. You would check a glucose. You would check a chest x-ray. You would

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listen to their lungs to see if they have a pneumothorax. You would administer medications, including epinephrine or bi-carb. You would see if they were bleeding. You would undertake this whole series of events to determine why they had arrested and what reversible causes of the arrest are present.

Q. Well, I guess I'm confused, because I would imagine if somebody came to an ER either in an ambulance, or their family member somehow brought them in, and they had no pulse and they were unresponsive, would you want to do something like CPR?

A. Oh, of course.

Q. Okay. And what else might you do?

A. So you would start with the ACLS algorithms. So you would start with chest compressions. You would intubate the patient. You would obtain IV access, and you would go down the pathways that I had previously discussed.

Q. Would you potentially administer an automated -- is it external defibrillator or electronic?

A. It's external. So, in the hospital we would not use an automated. We look at the rhythm ourselves and determine if a shock was required.

So an AED are those packs at airports where

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you can put it on the chest and then it tells you whether or not to deliver a shock. But we don't use those in the emergency department because we just don't.

Q. All right. Would an EMT have an AED?

A. Yes.

Q. Okay. Now, you mentioned PEA. Is PEA something that might be indicative of a sudden cardiac arrest?

A. PEA is one form of cardiac arrest.

Q. Now, I'm looking back at this article from UpToDate. It says, "Despite appropriate and expeditious management, some patients with severe methamphetamine intoxication will sustain sudden cardiovascular collapse." Can you explain what sudden cardiovascular collapse means?

A. So, typically it means that you -- your cardiac output cannot sustain the function required to keep you alive.

Q. And so, what do you interpret appropriate and expeditious management to mean in this setting?

A. So, if a patient presents I -- fluids, electrolyte replacement, dialysis as needed, cooling as needed.

Q. So, is it fair to say, then, that what this

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article from UpToDate is saying that despite having all those interventions -- I'm presuming a screening as well -- that some patients with severe methamphetamine intoxication can still experience a sudden cardiac event?

A. Yes.

Q. And then it says, "No predisposing factors rigorously predict collapse." So, is it also fair to say it's not necessarily predictable, even to a doctor, if sudden cardiac arrest or cardiovascular collapse will occur in a patient?

A. It's true that you can't always predict, but certainly if somebody comes in wildly agitated to the point that they need be to sedated, they will be kept in a hospital setting for the appropriate amount of time to hopefully be in the hospital when something untoward happens to them.

Q. Okay. So, are you saying that being in the hospital is better than not being in a hospital when something like this happens?

A. Yes.

Q. Okay. Um -- and this sentence here also interested me. It says "The multifactorial nature of cardiovascular collapse makes successful resuscitation notoriously difficult, even when arrest is witnessed."

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So, what do you think this means?

A. It means to me that it's probably difficult to resuscitate somebody who suffers from cardiovascular collapse in this setting.

Q. And so when you say in this setting, do you mean in the hospital?

A. I mean in the setting of methamphetamine toxicity.

Q. Okay. And I'm asking you about the part where it says "even when arrest is witnessed." Is it fair to say that when an arrest is witnessed it's more likely that somebody will get intervention?

A. Yes.

Q. So, is it fair to say, from what this article from UpToDate is telling us, is that even when somebody is getting that medical care that you would provide, which is the medical screening and all those interventions, and even when the patient is in the hospital, the patient can still have a cardiac event, such as sudden cardiovascular collapse or sudden cardiac arrest, that could be unable to be survivable; is that correct?

A. I mean, that's always the case. You can't be 100 percent sure that you are going to save everybody 100 percent of the time, even if you do your

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best.

Q. Okay. Are you aware of statistics about the percentage of patients who experience sudden cardiac arrest who survive?

A. I don't know the statistics off the top of my head, but I certainly can find them.

Q. In your best estimate, I would say, how -- are sudden cardiac arrests what you would categorize as treatable or a treatable life-threatening condition?

A. You can certainly treat somebody who is suffering cardiac arrest.

Q. But do you know, is the chance of death from a sudden cardiac arrest, is it more than 50 percent, in general?

A. It's high, especially for out-of-hospital cardiac arrest. The in-hospital cardiac arrest survival rates I think are better. But again, I don't know the specific numbers.

Q. Okay. Do you have any reason to dispute if the American Heart Association said that its in-house survival rate was less than 25 percent?

A. If that's what they say, I don't see any reason to dispute that.

Q. So, I noticed that sudden cardiac arrest is

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not something that's listed in either of your reports. Is there a reason why?

A. No, there is not. I -- if I had thought of it then I would have put it in there. I agree that you can certainly suffer from a sudden cardiac arrest.

Q. So you did not consider sudden cardiac arrest when listing treatable conditions, complications of meth toxicity; correct?

A. I did not in my opinion.

Q. Even though the fact of the matter is that Mr. Taylor was found in PEA, and that is a type of sudden cardiac arrest, you did not consider sudden cardiac arrest in any of your opinions?

A. So, PEA is also the endpoint of all the other causes that I did. PEA is not its own thing. PEA is the endpoint of all of the complications that I discussed.

Q. Okay. Um -- well, I really appreciate your time today, Doctor. I just want to confirm one last time that you will not be making any changes or additions to your opinions in this case, because this is the last time I will get to speak to you?

A. I will not be. I do have those E-mails, if you just want me to send them to you. I guess -- You seem like you had some tasks that you had given to me that I can complete. I would just like them to be listed out.

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Q. Sure. The first, any E-mails that you haven't produced yet. And then, finally, the articles that you relied on, if you could find -- you know, if it's easy to find. I don't want you to have to go photocopying, like, a textbook, but if you have PDFs or something that's easy for you to produce, I would really like to see that.

MS. LYMAN: And finally, then, Mabel, this is former Exhibit 8, which will now be marked as Exhibit 9.

(Exhibit 9 marked.)

Q. Dr. Harvey, this is your fee schedule for this matter; correct?

A. It is.

Q. I just want to make sure that you get paid for your time today. So if you wouldn't mind providing Mr. Buffington with a W-9 and an invoice, then he will send them to me and we will make sure that you get paid.

A. Thank you.

MS. LYMAN: All right. Thanks, everybody. I hope you all have a great weekend.

MR. BUFFINGTON: Can I ask a couple of questions?

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MS. LYMAN: Sure. I didn't want to cut you off there.

MR. BUFFINGTON: That's all right.

EXAMINATION

BY MR. BUFFINGTON:

Q. And I'm just following up on a few of the questions that were asked.

Doctor, I believe you, in forming your opinions or reaching your opinions, you reviewed a medical screening form that was completed by Ariel Lauing-Simms; is that correct?

A. That is correct.

Q. Okay. And there were -- that form had a -- a section of certain conditions that upon admission indicated or suggested the need for emergency services, among which were difficulty breathing, lacerations, skull deformity, hallucinations, vomiting blood, chest pains, and suicide suggestions.

A. Yes.

Q. Do you recall reading that?

A. I do.

Q. And do you agree that these conditions enumerated there or listed there, do, in fact, suggest the need for emergency services?

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MS. LYMAN: Objection, form and foundation.

A. I do think that patients who are displaying those should probably be evaluated by a medical professional.

Q. Okay. Now, in reviewing the materials that you reviewed, was it evident to you that Mr. Taylor at the time of his arrest, and at the jail, and while he was in the cell, was experiencing hallucinations?

A. Yes.

Q. Okay. And do you recall whether correctional Officer Lauing-Simms on the form, the screening form, indicated whether Mr. Taylor was experiencing hallucinations?

A. Well, will you bring up the form? Do you have the form?

Q. I can't, I'm sorry, right now.

A. I have it. It just takes me a second.

Q. Believe me, a few seconds is a lot less time than it will take me.

A. I just want to be clear. I have it in front of me, and I am going to hold up to the screen the form that you are referring to so I can be clear. Is this --

Q. That is.

A. So your question is?

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Q. What did that form indicate about whether or not Mr. Taylor was suffering from any of those listed conditions, difficulty breathing, lacerations, et cetera?

A. It is circled "no."

Q. Okay. So, as to those conditions, including hallucinations, Correctional Officer Lauing-Simms indicated no, he was not suffering from those?

A. Correct.

Q. Now, counsel asked you a number of questions about the possibility of cardiac arrest or cardiovascular collapse on the part of Mr. Taylor. Do you recall those questions?

A. I do.

Q. Now, from your review of the records, was Mr. Taylor in custody at the jail from approximately 8:33 until at least 12:05?

A. Yes.

Q. Okay. And during much of that time he was agitated, hallucinating, yelling, pacing in his cell?

MS. LYMAN: Objection, foundation.

Q. Okay. From your review of the records was that the case?

A. From what I have reviewed, yes.

Q. Okay. Now, if Mr. Taylor, while he was

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still upright and alive, if during the, say, three hours subsequent to his booking, if he had been transported for medical care and if he had received appropriate medical care, in your opinion could the conditions which contributed to or may have contributed to cardiovascular collapse have been addressed medically?

A. If he had been transported to a hospital and received a medical screening exam, I do believe that he would have started down a pathway in the hospital that very likely would have uncovered any medical emergencies for which he could have been treated. We don't know what those conditions were because he was not seen.

Q. If you could describe for us the contributing factors which, in your opinion, may have contributed to cardiac arrest or cardiovascular collapse on the part of Mr. Taylor?

A. So, not withstanding that I did not nor did any physician see this patient, certainly if a patient presented to me and they were severely agitated, I would be concerned that that agitation could have been a harbinger of some other medical problem. I think that he should have been evaluated. If needed, he should have been sedated and he should have been

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allowed to be observed over a period of time until he was no longer experiencing a medical emergency in the form of hallucinations or significant agitation. I think that not allowing him the opportunity to receive that medical care placed him at high risk for an adverse outcome.

Does that answer your question or am I --

Q. Yes, it does.

Specifically what would have been done to address, in an appropriate emergency room context, and in the context of Mr. Taylor, what would have been done to address his -- his -- I'm using a lay term -- his agitation and movement, excessive movement?

A. Well, that's not a lay term. That's a term we use as well. So, if a patient came into my emergency department and I saw him, I would be concerned about the hallucinations and what was causing them. Certainly methamphetamine is a possibility. Alcohol withdrawal is certainly a possibility, particularly in New Mexico, and that can cause hallucinations.

You also have to think about a first psychotic break. This is a young man who was at the age where he may develop psychosis from a psychiatric standpoint.

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So what I would have done, I would have assessed him, gotten a set of vital signs. If he was persistently hallucinating and agitated, I would have started with benzodiazepine, which is the first line treatment for these agitated delirium patients. There are others available like ketamine and haldol, but I think benzos are the safest, and certainly the first line.

I would have placed -- had the nurses place an IV. I would have checked the labs on him to see if he was suffering from renal failure, hyperkalemia, any electrolyte abnormalities. He would have received IV fluids.

If he was very combative and not making sense throughout the course of the evening, I would have checked a head CT. And every -- every step stems from the previous step, and stems from what you see first when you evaluate the patient, and then during the observation of the patient over time.

I don't know the resources available at NNMC. I have never worked there. But in my hospital, I would have monitored this patient who was actively hallucinating, and hallucinations are different than delusions or paranoia. Hallucinations is seeing other things in the room or hearing other things in the

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A. I think that if a patient was presenting to the hospital, they would probably -- I mean, it depends what they are there for. It really depends on who they encounter and why they are there. If there's a security situation, if somebody is being violent or disruptive in the waiting room, or somebody is concerned there is a security situation, they probably call security. If it looked like they needed medical help, they would probably be seen by the triage nurse.

Q. And let's say hypothetically somebody came into the waiting area of the emergency department at your hospital warning everybody that aliens are coming?

A. Uh-huh.

Q. How do you think that would be handled by your staff?

A. I don't know how that would be handled. If they -- it depends on who they encounter. If they encounter a security guard first, I would assume they would try to assess the situation for safety would be the very first step.

Q. Does your hospital, your emergency department frequently call police to take people away who are disruptive?

A. We have called the police in the past if we

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think that there is a dangerous situation.

Q. And so, do those calls get made without the input of any kind of physician or nurse?

A. I don't -- I don't know the answer to that question. I don't know everything that happens on the hospital campus at all times.

Q. Were you ever asked in this case to provide an analysis or opinion about the conduct of anybody at Northern Navajo Medical Center?

A. No.

MS. LYMAN: Okay. I think that's it for me. Thank you.

MR. BUFFINGTON: Okay. Read and sign.

MS. LYMAN: Okay. Fine with me.

(The deposition concluded at 12:54 p.m.)

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

MINNIE TAYLOR, Individually and as Personal Representative of the ESTATE OF LOUIE TAYLOR, and HAROLD CUTHAIR,

Plaintiffs,

vs. Case No. 21-cv-00613-GJF-JFR

THE UNITED STATES OF AMERICA,

Defendant.

CERTIFICATE OF COMPLETION OF DEPOSITION

I, MABEL JIN CHIN, New Mexico CCR #81, DO HEREBY CERTIFY that on March 25, 2022, the deposition of VIRGINIA E. HARVEY, M.D. was taken before me at the request of, and sealed original thereof retained by:

Attorney for Defendant
FRED J. FEDERICI
United States Attorney
Post Office Box 607
Albuquerque, New Mexico 87103
BY: MS. CHRISTINE H. LYMAN

I FURTHER CERTIFY that copies of this certificate have been mailed or delivered to all counsel, and parties to the proceedings not represented by counsel, appearing at the taking of the deposition.

I FURTHER CERTIFY that examination of this transcript and signature of the witness was required by the witness and all parties present.

On_____ a letter was mailed or delivered to Mr. Buffington regarding obtaining signature of the witness, and corrections, if any, were appended to the original and each copy of the deposition.

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I FURTHER CERTIFY that the recoverable cost of the original and one copy of the deposition, including exhibits to Ms. Lyman is $_____.

I FURTHER CERTIFY that I did administer the oath to the witness herein prior to the taking of this deposition; that I did thereafter report in stenographic shorthand the questions and answers set forth herein, and the foregoing is a true and correct transcript of the proceeding had upon the taking of this deposition to the best of my ability.

I FURTHER CERTIFY that I am neither employed by nor related to nor contracted with (unless excepted by the rules) any of the parties or attorneys in this case, and that I have no interest whatsoever in the final disposition of this case in any court.

_____

MABEL JIN CHIN
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License expires: 12/31/2022

(6380N) MC
Date taken: March 25, 2022
Proofread by: LR

Exhibit D